Big Horn
DENTAL CLINIC

Release of Information

Patient Name: _____

DOB: ____/____/____

I authorize the mutual exchange of information about my dental care, treatment, and account/payment information between:

Big Horn Dental Clinic
4403 Running W Drive
Gillette, WY 82718
307-686-1567

and

Name: _____
Address: _____

Phone Number: _____

Restrictions of release (if any):

_____

_____

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____
(if patient is under 18 years of age)

Witness: _____ Date: _____

Updated: 7/13/20